House of Representatives

General Assembly

File No. 672

February Session, 2014

Substitute House Bill No. 5378

House of Representatives, April 24, 2014

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-261m of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may contract with one or more administrative services organizations to provide care coordination, utilization management, disease management, customer service and review of grievances for recipients of assistance under Medicaid and HUSKY Plan, Parts A and B. Such organization may also provide network management, credentialing of providers, monitoring of copayments and premiums and other services as required by the commissioner. Subject to approval by applicable federal authority, the Department of Social Services shall utilize the contracted

organization's provider network and billing systems in the administration of the program. In order to implement the provisions of this section, the commissioner may establish rates of payment to providers of medical services under this section if the establishment of such rates is required to ensure that any contract entered into with an administrative services organization pursuant to this section is cost neutral to such providers in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(b) Any contract entered into with an administrative services organization, pursuant to subsection (a) of this section, shall include a provision to reduce inappropriate use of hospital emergency department services, which may include a cost-sharing requirement. Such provision **[**may include**]** shall require intensive case management services, **[**and a cost-sharing requirement.**]** including, but not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and emergency department use is at its highest. For purposes of this section and sections 17a-476 and 17a-22f, as amended by this act, "frequent users" means a Medicaid client with ten or more annual visits to a hospital emergency department.

(c) The commissioner shall ensure that any contracts entered into with an administrative services organization include a provision requiring such administrative services organization to (1) conduct assessments of primary care doctors and specialists to determine patient ease of access to services, including, but not limited to, the wait

times for appointments and whether the provider is accepting new Medicaid clients, and (2) perform outreach to Medicaid clients to (A) inform them of the advantages of receiving care from a primary care provider, (B) help to connect such clients with primary care providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with primary care providers not later than fourteen days after such clients are treated at an emergency department.

(d) The Commissioner of Social Services shall require an administrative services organization with access to complete client claim adjudicated history to analyze and annually report, not later than February first, to the Department of Social Services and the Council on Medical Assistance Program Oversight, on Medicaid clients' use of hospital emergency departments. The report shall include, but not be limited to: (1) A breakdown of the number of unduplicated clients who visited an emergency department, and (2) for frequent users of emergency departments, (A) the number of visits categorized into specific ranges as determined by the Department of Social Services, (B) the time and day of the visit, (C) the reason for the visit, (D) whether hospital records indicate such user has a primary care provider, (E) whether such user had an appointment with a community provider not later than fourteen days after the date of the hospital emergency department visit, and (F) the cost of the visit to the hospital and to the state Medicaid program. The Department of Social Services shall monitor its reporting requirements for administrative services organizations to ensure all contractually obligated reports, including any emergency department provider analysis reports, are completed and disseminated as required by contract.

(e) The Commissioner of Social Services shall use the report required pursuant to subsection (d) of this section to monitor the performance of an administrative services organization. Performance measures monitored by the commissioner shall include, but not be limited to, whether the administrative services organization helps to arrange visits by frequent users of emergency departments to primary

care providers not later than fourteen days after treatment at an emergency department.

Sec. 2. (NEW) (*Effective July 1, 2014*) Not later than January 1, 2015, the Commissioner of Social Services shall require that state-issued Medicaid benefits cards contain the name and contact information for a Medicaid client's primary care provider, if such client has chosen a primary care provider.

Sec. 3. Section 17a-476 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) Any general hospital, municipality or nonprofit organization in Connecticut may apply to the Department of Mental Health and Addiction Services for funds to establish, expand or maintain psychiatric or mental health services. The application for funds shall be submitted on forms provided by the Department of Mental Health and Addiction Services, and shall be accompanied by (1) a definition of the towns and areas to be served; (2) a plan by means of which the applicant proposes to coordinate its activities with those of other local agencies presently supplying mental health services or contributing in any way to the mental health of the area; (3) a description of the services to be provided, and the methods through which these services will be provided; and (4) indication of the methods that will be employed to effect a balance in the use of state and local resources so as to foster local initiative, responsibility and participation. In accordance with subdivision (4) of section 17a-480 and subdivisions (1) and (2) of subsection (a) of section 17a-484, the regional mental health board shall review each such application with the Department of Mental Health and Addiction Services and make recommendations to the department with respect to each such application.

(b) Upon receipt of the application with the recommendations of the regional mental health board and approval by the Department of Mental Health and Addiction Services, the department shall grant such funds by way of a contract or grant-in-aid within the appropriation for any annual fiscal year. No funds authorized by this section shall be

used for the construction or renovation of buildings.

(c) The Commissioner of Mental Health and Addiction Services shall require an administrative services organization with which it contracts to manage mental and behavioral health services to provide intensive case management. Such intensive case management shall include, but not be limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

[(c)**]** (d) The Commissioner of Mental Health and Addiction Services may adopt regulations, in accordance with the provisions of chapter 54, concerning minimum standards for eligibility to receive said state contracted funds and any grants-in-aid. Any such funds or grants-in-aid made by the Department of Mental Health and Addiction Services for psychiatric or mental health services shall be made directly to the agency submitting the application and providing such service or services.

Sec. 4. Section 17a-22f of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) The Commissioner of Social Services may, with regard to the provision of behavioral health services provided pursuant to a state plan under Title XIX or Title XXI of the Social Security Act: (1) Contract with one or more administrative services organizations to provide

clinical management, intensive case management, provider network development and other administrative services; (2) delegate responsibility to the Department of Children and Families for the clinical management portion of such administrative contract or contracts that pertain to HUSKY Plan Parts A and B, and other children, adolescents and families served by the Department of Children and Families; and (3) delegate responsibility to the Department of Mental Health and Addiction Services for the clinical management portion of such administrative contract or contracts that pertain to Medicaid recipients who are not enrolled in HUSKY Plan Part A.

(b) For purposes of this section, the term "clinical management" describes the process of evaluating and determining the appropriateness of the utilization of behavioral health services and providing assistance to clinicians or beneficiaries to ensure appropriate use of resources and may include, but is not limited to, authorization, concurrent and retrospective review, discharge review, quality management, provider certification and provider performance enhancement. The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall jointly develop clinical management policies and procedures. **[**The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to existing behavioral health policies and procedures concerning utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.**]**

(c) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall require that administrative services organizations managing behavioral health

services for Medicaid clients develop intensive case management that includes, but is not limited to: (1) The identification by the administrative services organization of hospital emergency departments which may benefit from intensive case management based on the number of Medicaid clients who are frequent users of such emergency departments; (2) the creation of regional intensive case management teams to work with emergency department doctors to (A) identify Medicaid clients who would benefit from intensive case management, (B) create care plans for such Medicaid clients, and (C) monitor progress of such Medicaid clients; and (3) the assignment of at least one staff member from a regional intensive case management team to participating hospital emergency departments during hours when Medicaid clients who are frequent users visit the most and when emergency department use is at its highest.

(d) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services shall ensure that any contracts entered into with an administrative services organization require such organization to (1) conduct assessments of behavioral health providers and specialists to determine patient ease of access to services, including, but not limited to, the wait times for appointments and whether the provider is accepting new Medicaid clients; and (2) perform outreach to Medicaid clients to (A) inform them of the advantages of receiving care from a behavioral health provider, (B) help to connect such clients with behavioral health providers soon after they are enrolled in Medicaid, and (C) for frequent users of emergency departments, help to arrange visits by Medicaid clients with behavioral health providers not later than fourteen days after such clients are treated at an emergency department.

(e) The Commissioners of Social Services, Children and Families, and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid reimbursement are submitted to the Centers for Medicare and Medicaid Services.

(f) The Department of Social Services may implement policies and procedures necessary to carry out the purposes of this section, including any necessary changes to procedures relating to the provision of behavioral health services and utilization management, while in the process of adopting such policies and procedures in regulation form, provided the Commissioner of Social Services publishes notice of intention to adopt the regulations in accordance with the provisions of section 17b-10 not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are adopted.

Sec. 5. Section 17b-241a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

Notwithstanding any provision of the general statutes**,** **[**and the regulations of Connecticut state agencies,**]** the Commissioner of Social Services may reimburse the Department of Mental Health and Addiction Services for targeted case management services that it provides to its target population, which, for purposes of this section, shall include individuals with severe and persistent psychiatric illness and individuals with persistent substance dependence. The Commissioners of Social Services and Mental Health and Addiction Services, in consultation with the Secretary of the Office of Policy and Management, shall ensure that all expenditures for intensive case management eligible for Medicaid reimbursement are submitted to the Centers for Medicare and Medicaid Services.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	17b-261m
Sec. 2	*July 1, 2014*	New section
Sec. 3	*July 1, 2014*	17a-476
Sec. 4	*July 1, 2014*	17a-22f
Sec. 5	*July 1, 2014*	17b-241a

APP *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 $	FY 16 $
Social Services, Dept.	GF - Potential Savings	See Below	See Below

Municipal Impact: None

Explanation

Sections 1 and 3 through 5 require the Departments of Social Services (DSS), Mental Health and Addiction Services (DMHAS) and Children and Families (DCF), through their contract with their administrative services organizations (ASO), to provide intensive case management (ICM) services to Medicaid clients, including those with behavioral health needs. ICM is already being utilized in the Medicaid population. To the extent that this bill results in additional clients being served by ICM or results in an impact on the mix of services being utilized by Medicaid clients, there may be savings to the state. A 1% reduction in total annual emergency department expenditures will result in a $2.3 million savings. The ASO ICM services in the bill are targeted at all Medicaid clients who might benefit from ICM, but particularly high utilizers of emergency departments. The bill requires various reporting and assessment requirements of the ASO which are not anticipated to result in a cost to the state Medicaid program. Lastly, the bill requires DSS and DMHAS, in consultation with the Office of Policy and Management to ensure all expenditures for ICM eligible for reimbursement be submitted to the Centers for Medicare and Medicaid Services.

Section 2 does not result in a fiscal impact to the DSS. The section

requires DSS to print the name and contact information of the Medicaid client's primary care physician, if one has been chosen, on a state issued Medicaid benefits card.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

sHB 5378

AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY DEPARTMENT VISITS.

SUMMARY:

The departments of Social Services (DSS), Children and Families (DCF), and Mental Health and Addiction Services (DMHAS) contract with administrative service organizations (ASOs) to administer and manage the medical and behavioral health services provided to Medicaid recipients. This bill requires these ASOs to also provide intensive case management services that, among other things, (1) identify hospital emergency departments (EDs) with high numbers of "frequent users" (i.e., Medicaid clients with 10 or more annual ED visits), (2) create regional intensive case management teams to work with ED doctors, and (3) assign at least one regional intensive case management team staff member to participating EDs during the EDs' hours of highest use.

The bill also requires these ASOs to (1) assess medical and behavioral health providers on certain criteria including ease of access and (2) perform outreach to Medicaid clients to encourage their use of these providers. The bill additionally requires certain DSS-contracted ASOs to annually report to DSS and the Council on Medical Assistance Program Oversight (MAPOC) information on Medicaid clients', including frequent users', ED use. Under the bill, the DSS commissioner must use the reports to monitor the ASOs' performance.

Finally, the bill requires state-issued Medicaid benefits cards to include the name and contact information for the Medicaid beneficiary's primary care provider, if he or she has chosen one.

EFFECTIVE DATE: July 1, 2014

INTENSIVE CASE MANAGEMENT

Contract Requirements

The bill requires certain DSS, DCF, and DMHAS contracts with ASOs to provide for intensive case management services. This requirement applies to (1) DSS contracts with ASOs providing care coordination and other services for Medicaid and HUSKY A and B; (2) DMHAS contracts with ASOs managing mental and behavioral health services; and (3) DSS, DCF, and DMHAS (i.e., the Connecticut Behavioral Health Partnership) contracts with ASOs managing behavioral health services for Medicaid clients. Current law allows, but does not require, DSS to include intensive case management services in its Medicaid and HUSKY contracts with ASOs.

Definition and Scope of Intensive Case Management

Under the bill, the intensive case management services provided by the ASOs must (1) identify, based on their numbers of frequent users, EDs that may benefit from the provision of intensive case management services to those users; (2) create regional intensive case management teams that work with doctors to (a) identify Medicaid clients who may benefit from intensive case management, (b) create care plans for them, and (c) monitor their progress; and (3) assign at least one team member to each participating ED during times when ED use is highest and frequent users visit most.

The bill directs the agencies, in consultation with the Office of Policy and Management secretary, to submit their eligible expenditures for intensive case management for reimbursement to the Centers for Medicare and Medicaid Services (CMS).

ASO Assessments

The bill requires ASOs in contracts with (1) DSS to assess primary care providers and specialists and (2) the Connecticut Behavioral Health Partnership to assess behavioral health providers and specialists. The assessments must determine how easily Medicaid

patients may access provider or specialist services by considering waiting times for appointments and whether a provider is accepting new Medicaid clients. ASOs must also perform outreach to Medicaid clients to (1) inform them of the advantages of receiving care from these providers, (2) help connect clients with providers as soon as they are enrolled in Medicaid, and (3) help arrange visits with providers for frequent users within 14 days of an ED visit.

Reporting Requirements

The bill requires ASOs that (1) contract with DSS to provide care coordination for Medicaid and HUSKY and (2) have access to complete client claim adjudicated history, to report annually, by February 1, to DSS and MAPOC. The report must include the number of unduplicated Medicaid clients who visited an ED and, for frequent users:

1. the number of visits, grouped into DSS-determined ranges;
2. the time and day of the visit;
3. the reason for the visit;
4. if the client has a primary care provider;
5. if the client had an appointment with a community provider within 14 days after the date of the ED visit; and
6. the cost to the hospital and the state Medicaid program of the client's visit.

The DSS commissioner must use these annual reports to monitor the ASOs' performance. Performance measures must include whether the ASO helps frequent users arrange visits to primary care providers within 14 days after an ED visit. The bill requires DSS to monitor contractual reporting requirements for ASOs to ensure reports are completed and disseminated as required.

BACKGROUND

Legislative History

The House referred the original bill (File 211) to the Appropriations Committee, which reported a substitute that eliminated requirements that (1) children found eligible for HUSKY A and B remain eligible for at least 12 months in most circumstances (i.e., continuous enrollment); (2) DSS seek federal approval for a 12-month continuous eligibility period for Medicaid-eligible adults; and (3) DSS establish a demonstration project to offer telemedicine, telehealth, or both as Medicaid covered services at federally qualified health centers.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute
Yea 11 Nay 0 (03/13/2014)

Appropriations Committee

Joint Favorable Substitute
Yea 44 Nay 0 (04/15/2014)